

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CabaretCity or town Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cabaret Co. 7th St.How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CabaretCity or town Solomons
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2. (a) If veteran, name war WW

3. (a) FULL NAME

George W. Elliott

3. (b) Social Security Number

No

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Mellie Elliott

7. Birth date of

deceased (mo., day, yr.)

Mar. 19, 18906. (c) If alive, give age 53 years

8. AGE:

Years

Months

Days

If less than one day

56105

hrs.

min.

9. Birthplace

Solomons, Md
(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

FATHER

12. Name

Geo. W. Elliott

13. Birthplace

Md.

MOTHER

14. Maiden name

Annie Brewer

15. Birthplace

Md

16. Informant

Mellie Elliott

Address

Solomons17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 27, 1947
(month) (day) (year)

Cemetery or crematory

San John's Star of Sea

Location

Solomons, Md.

18. Funeral director

A. J. Harkness & Son

Address

Mutual19. 1-25-

(Date rec'd by registrar)

19. 47Harkness

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1947 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 24, 1947 to Jan. 24, 1947and that I last saw him alive on Jan. 24, 1947

Immediate cause of death

Cerebral
Malignant. Surg.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

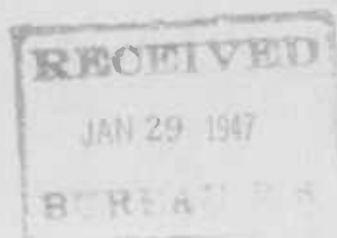
23. SIGNATURE

George W. Elliott

M. D. or other

Address

Prince Frederick, Md.Date signed 1-25-47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00352 10

1. PLACE OF DEATH:

County Calvert
 City or town Prince Frederick, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Carroll Gray.

3. (b) Social Security Number

4. Sex

m

5. Color or race

C

6. (a) Single, married, widowed, or divorced

x

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

may1931

8. AGE:

Years

Months

Days

If less than one day

16

..... hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name

Willie Gray.

13. Birthplace

md

14. Maiden name

Margaret Butler

15. Birthplace

md.

16. Informant

Willie Gray.

Address

Mutual Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof.

(month) (day) (year)

Cemetery or crematory

Island Creek, Md.

Location

Calvert.

18. Funeral director

P. E. Sewell.

Address

Prince Frederick, Md.

19.

(Date rec'd by registrar)

19 47H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Mutual.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1, 1947, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to Jan 1, 19 47

and that I last saw him..... alive on 19.....

Immediate cause of death

DURATION

DiabetesDue to Diabetic coma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00358 98

Reg. Dist. No. 510

1. PLACE OF DEATH: *Calvert*
 County.....
 City or town.....*Prince Frederick, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Calvert*
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Arthur Gross.

3. (b) Social Security Number

4. Sex.....*M.* 5. Color or race.....*C* 6.(a) Single, married, widowed, or divorced.....*X*
 6.(b) Name of husband or wife.....*Alice Gross.*
 6.(c) If alive, give age.....*22* years
 7. Birth date of deceased (mo., day, yr.).....*March 15, 1911*
 8. AGE: Years.....*36* Months.....*10* Days.....*6* If less than one day..... hrs. min.

9. Birthplace.....*Md.*
 (Town, county, and state)

10. Usual occupation.....*Laborer.*

11. Industry or business

FATHER 12. Name.....*Samuel Gross.*
 13. Birthplace.....*Md.*

MOTHER 14. Maiden name.....*Mary Parran.*
 15. Birthplace.....*Md.*

16. Informant.....*Samuel Gross*

Address.....*Prince Frederick, Md.*

17. *Burial* (Burial, cremation, or removal. Which?) Date thereof.....*1-24-47*
 (month) (day) (year)

Cemetery or crematory.....*Carrolls,*

Location.....*Calvert.*

18. Funeral director.....*P.E. Sewell*

Address.....*Prince Frederick, Md.*
 19. *1-21* 19 *47* *N.W. Ward*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*1-21* 19 *47* at.....*2:45*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*1946* to.....*Jan 21, 1947*
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....*Respiratory Failure*
 DURATION

Due to.....*Poliomyelitis*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....*R de Villanar*

Address.....*Prince Frederick* Date signed.....*Jan 23/47*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 29 1947

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2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 518

1. PLACE OF DEATH:

County Calvert
 City or town Lusby, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert
 City or town Lusby, Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary F Johnson

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced X

6.(b) Name of husband or wife Esau Johnson
 6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May, 2, 1878

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Md
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business _____

12. Name Youngers Cephew13. Birthplace Virginia14. Maiden name Not Known

15. Birthplace _____

16. Informant Esau JohnsonAddress Lusby, Md

17. Burial Date thereof 1-26-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Johns
Calvert

Location P.E. Sewell
Prince Frederick, Md

18. Funeral director Prince Frederick, Md

Address _____

19. 1-25 1947 H. W. Ware
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Jan 19 47 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Jan 19 47 to 23 Jan 19 47

and that I last saw him alive on 23 Jan 19 47

Immediate cause of death Chronic myocarditis

Due to atherosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE [Signature] M. D. or other _____

Address Huntingtown Date signed 24 Jan 47

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Evidence for the change of
age is shown on
G 108 1/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No. 510

1. PLACE OF DEATH: Calvert Hospital.
County.....
City or town Prince Frederick, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Calvert
City or town Paris, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) if veteran, name war

3. (a) FULL NAME Charolette Jones.

3. (b) Social Security Number

4. Sex F 5. Color or race C. 6.(a) Single, married, widowed, or divorced X

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1890 6.(c) If alive, give age..... years

8. AGE: Years 56 Months 5/0 Days If less than one day
..... hrs. min.

9. Birthplace Maryland
(Town, county, and state) domestic

10. Usual occupation

11. Industry or business

12. Name John Foster.
13. Birthplace Md.

14. Maiden name Sarah Jones.
15. Birthplace Md

16. Informant William Jones.
Address Paris, Md.

17. Burial. Date thereof 1-18-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mt Hope
Location Calvert

18. Funeral director P.E. Sewell.
Address Prince Frederick, Md.

19. 1-18 19 47 H. W. Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14- 19 47, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Jan 19 47 to 14 Jan 19 47 and that I last saw him alive on 14 Jan 19 47

Immediate cause of death Peritonitis DURATION

Due to intestinal obstruction

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE H. W. Ward M. D. or other
Address Huntingtown Date signed 17 Jan 47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 29 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 518

1. PLACE OF DEATH:

County Calvert
City or town Bunkirk, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert
City or town Bunkirk, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Alexander C. Mackall

3. (b) Social Security Number

4. Sex

M.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Feb, 17, 1945

8. AGE:

Years

Months

Days

If less than one day

1118

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

Earlhart Mackall

13. Birthplace

Md.

14. Maiden name

Virginia Jenkins

15. Birthplace

Md.

16. Informant

Earlhart Mackall

Address

Bunkirk, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

1-25-47
(month) (day) (year)

Cemetery or crematory

Halls Creek

Location

Calvert

18. Funeral director

P. E. Sewell

Address

Prince Frederick Md

19.

1-26
(Date rec'd by registrar)19 47N-W Ward
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24, 19 47, at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Asphyxiation

DURATION

Due to

Heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Overdose Date of 2 Jan 47Where did injury occur? Bunkirk Calvert Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Home

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Huntingtown Date signed 25 Jan 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 29 1947

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JAN 29 1947

BUREAU V. G.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert
 City or town Blunkirk, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert
 City or town Blunkirk, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Gilbert D. Mackall.

3. (b) Social Security Number

4. Sex m. 5. Color or race c 6.(a) Single, married, widowed, or divorced _____

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1943 6.(c) If alive, give age _____ years

8. AGE: Years 3 Months 3 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Earlhart Mackall.13. Birthplace Md.14. Maiden name Virginia Jenkins15. Birthplace Md.16. Informant Earlhart Mackall.Address Blunkirk, Md.17. Burial Date thereof 1-25-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Halls CreekLocation Calvert18. Funeral director P. E. SewellAddress Prince Frederick Md.19. 1-21- 47 Newman

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24, 19 47, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____ and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Diffusion

Due to Lung

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 24 Jan 47Accident, suicide, or homicide Overdose Date of 24 Jan 47Where did injury occur? Blunkirk Calvert Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Home

Means of injury _____ Injured at work?

23. SIGNATURE Gilbert D. Mackall Virginia Jenkins

M. D. or other _____

Address Blunkirk Calvert Date signed 24 Jan 47

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JAN 29 1947

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JAN 29 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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72

Reg. Dist. No. 510

1. PLACE OF DEATH:

County Calvert
 City or town Sunderland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert
 City or town Sunderland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Frances Reid.

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced X

6.(b) Name of husband or wife Joseph Reid.

7. Birth date of deceased (mo., day, yr.) April, 1874 6.(c) If alive, give age 74 years

8. AGE: Years 68 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name F

13. Birthplace

14. Maiden name Hannah Gray.15. Birthplace md.16. Informant Joseph Reid.Address Sunderland.17. Burial Date thereof 1-7-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mt Hope.Location Calvert Co. md.18. Funeral director P.E. Sewell.Address Prince Frederick, md.19. 1-6 19 47 N.W. Ware

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3-47 1947 at 10³⁰ PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Cardiac Failure.Due to Myocardium a.v.d.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. E. Sewell M. D. or other _____Address Prince Frederick Date signed Jan 6/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 522

1. PLACE OF DEATH:

County Calvert Hospital
 City or town Prince Frederick
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bertha Rice

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife

Stephen Rice

7. Birth date of

deceased (mo., day, yr.)

Nov. 10, 18916. (c) If alive, give age 57 years

8. AGE:

Years

Months

Days

If less than one day

56

hrs.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER
MOTHER

12. Name

John Wallace

13. Birthplace

md

14. Maiden name

Mary Adams

15. Birthplace

md

16. Informant

Stephen Rice

Address

Paris, md

17.

(Burial, cremation, or removal. Which?)

Date thereof

1, 12, 47
(month) (day) (year)

Cemetery or crematory

mt Hope

Location

Calvert

18. Funeral director

P. F. Sewell

Address

Prince Frederick md

19.

(Date rec'd by registrar)

19 47Grace P. Hutchins
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Paris, md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Jan 19 47 at 6 59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 Dec 19 44 to 8 Jan 19 47and that I last saw her alive on 8 Jan 19 47

Immediate cause of death

Pneumonia -
bronchitis

DURATION

2 weeksDue to Colitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

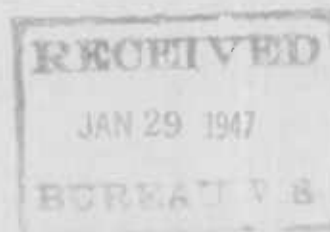
Injured at work?

23. SIGNATURE [Signature]

M. D. or other

Address

Date signed



2-25

2-520-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 510

1. PLACE OF DEATH:

County CalvertCity or town Mutual
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County CalvertCity or town Mutual
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph Saunders

3. (b) Social Security Number

4. Sex

m

5. Color or race

C

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife

Henrietta Saunders

7. Birth date of

deceased (mo., day, yr.)

may 23rd 18906.(c) If alive, give age 58 years

8. AGE:

Years

Months

Days

If less than one day

57

.....hrs.min.

9. Birthplace

md.

(Town, county, and state)

10. Usual occupation

Saborev

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

Cemetary or crematory

Location

18. Funeral director

Address

19. 1-18

19 17

X. W. Ward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17, 1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4, 1947 to 1947and that I last saw him alive on January 19, 1947

Immediate cause of death

Mental Deterioration

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Mutual, Calvert Date signed 1/18/47

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JAN 29 1947

BUREAU 78

2-3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CabretCity or town Bowens
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CabretCity or town Bowens
(If outside city or town limits, write RURAL and give nearest town)Street No. 720
(If rural, give LOCATION)2. (a) If veteran, name war 720

3. (a) FULL NAME

Marion Kay Simmons

3. (b) Social Security Number

704. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 29, 18778. AGE: Years 69 Months 5 Days 7 If less than one day hrs. min.9. Birthplace Cabret Co., Md
(Town, county, and estate)10. Usual occupation Farmer

11. Industry or business

12. Name Calvin W. Simmons13. Birthplace Md14. Maiden name Annie Skinner15. Birthplace Md16. Informant Sally J. SimmonsAddress Bowens Md17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 9, 1947
(month) (day) (year)Cemetery or crematory Pirate Simmons LotLocation Bowens18. Funeral director A. A. Warkness & SonAddress Mutual, Md19. 1-8 1947 W. W. Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1947, at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19Immediate cause of death Death by cardiac failureDue to hypertension

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00369

1. PLACE OF DEATH:

County Calvert
City or town Lower Marlboro Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Calvert
City or town Lower Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Eissman

3. (b) Social Security Number

SPICKNALL

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years 94 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business _____

12. Name Charles William Spicknall

13. Birthplace Md

14. Maiden name Elizabeth Ireland

15. Birthplace Md

16. Informant Mrs. Owens & Sons

Address Dunkirk Md

17. Burial Date thereof Jan 26 '47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lower Marlboro Cemetery

Location Lower Marlboro Md.

18. Funeral director W. H. Hutchins & Sons

Address Owings

19. Jan 25 19 47 Elmer M. Coe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 24 19 47 at 10-5-5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 21 19 45 to Jan 23 19 47
and that I last saw him alive on January 23 19 47

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Page C. Jeff

M. D. or other _____

Address Prince Frederick Md. Date signed 1-25-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

100-100000

INVESTIGATION OF CRIMES

ADMINISTRATIVE RECORDS

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UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF CRIMES

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1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 510

1. PLACE OF DEATH:

County Cabot
 City or town Prince Frederick, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

69

3

15

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1-25-47

W. Howard

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

1430

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JAN 29 1947

BUREAU OF

1-35